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PPS Alert for Long-Term Care

Excerpted from Volume 20 Issue No. 4 APRIL 2017

Medicare fraud and improper payments remain black stain under President Trump's microscope

An alarming fact: Medicare loses more money to overbilling than any other program government-wide. The Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) program, which is used to estimate improper payments made by Medicare, determined that more than $130 billion has been inappropriately lost by Medicare over the past three years due to improper payments. Even more disturbing, healthcare officials warn that without a change in payment distribution, the Medicare Trust Fund is on a path to becoming bankrupt by 2028.

In the past, long-term care providers have functioned under a payment system that rewards volume and complexity of healthcare services administered, introducing a monetary incentive for presenting sicker residents. Now, this payment system, otherwise known as Medicare, is advancing toward one that rewards quality and efficiency.

"I think a fee-for-service model is an easier one to account for when billing than a value-based one," says **Anthony Cirillo, FACHE, ABC,** President of The Aging Experience. "I agree that value-based should be the future as it rewards the right incentives. However, CMS just announced a halt to some bundled payment programs; the Innovation Center is under siege; and less regulation seems to be the new norm. So I don't see fee-for-service changing in the near term though I think providers should operate with a value-based mindset because it is the right thing to do."

Despite changes in how funds are administered, rising healthcare expenses and quickly depleting Medicare funds have put federal agencies up against a red hot timeline to rein in costs by uncovering instances of waste, fraud, and abuse, leaving some facilities with large settlement fines and in some extreme cases, jail sentences.

The future of Medicare

Medicare was first designated high-risk in 1990 by the Government Accountability Office (GAO) "due to its size, complexity, and susceptibility

to mismanagement and improper payments," and continues to make the agency's list of challenges each year.

The current challenge paints a picture of providers submitting claims while Recovery Audit Contractors (RAC) burn the other end of the candle, recovering improper payments and fraudulent claims in a mad race to keep it alight. To add to the issue, the health problems of the elderly are only becoming more complex, requiring more skilled services. With advancements in technology offering more opportunities to care for these complexities, it's unclear whether this will increase or decrease Medicare spending; in 2013, however, the OIG reported that technological change had likely been the dominant cause (accounting for 36 to 55 percent) of the increases in overall U.S. healthcare per capita spending over the past several decades.

President Donald Trump's budget blueprint for 2018 released on March 16 proposes plans to continue the anti-waste crackdown with an increase in funding for the Health Care Fraud and Abuse Control (HCFAC) program by $70 million, allotting a total of $751 million to the department for identifying and preventing fraudulent or improper Medicare payments.

Specifically, the proposed budget states its goal of "strengthen[ing] the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse and promote high quality and efficient health care."

Seema Verma, newly appointed Administrator for CMS, revealed in a statement during her confirmation hearing in February that her goals for Medicare are aligned with these initiatives spelled out in the budget blueprint, saying, "I will ensure that efforts around preventing fraud and abuse are a priority, since we cannot afford to waste a single taxpayer dollar. Ultimately, while we strive to provide the highest level of care to our current beneficiaries, we must solidify the programs' sustainability for future generations."

Though not out of the woods yet, the government's focus over the past few years on fighting healthcare fraud (beginning with the Obama Administration in 2015) is paying off—literally. In 2015, CMS was able to recover $4.1 billion in taxpayer dollars, compared to $1 billion recovered four years prior.

Additionally, says **Kristin Walter,** spokesperson for the Council for Medicare Integrity, in 2012, "a RAC

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Prepayment Demonstration Project was launched to test the effectiveness of RAC review of Medicare claims on a pre-payment basis. RACs have been successfully auditing Medicare claims on a post payment basis since 2009. As a result of the short but successful pre-pay audit pilot program, CMS and Congress are considering adding permanent RAC pre-pay audits. In fact, the GAO has highly recommended adding RAC prepay audits to Medicare integrity efforts to catch improper payments before they are paid out," she says.

How providers can help prevent fraud and improper payments

"Medicare fraud is considered to be intentional misbilling in an effort to make a profit from the program," says Walter. "CMS has stepped up efforts to identify and prosecute fraud via a new Fraud Prevention System (FPS) and the continued work of the ZPICs and FBI. In FY2013, CMS' FPS identified 938 Medicare providers and suppliers that were found to be billing fraudulently."

Improper payments, on the other hand, are often the result of incomplete or inaccurate documentation and billing errors, which can be unintentional and due to a lack of education or review. Ensuring documentation and billing claims are correct plays a vital role in preventing improper payments made by Medicare by eliminating the risk for subjective assessments that can later be questioned during surveys and audits. "Improper payments in Medicare occur when billing mistakes are made—often billing to the wrong code, duplicating the submission of a claim, or failing to provide the correct documentation for medical necessity," says Walter. She explains that "when an improper payment is detected by Recovery Auditors, providers are given an opportunity to correct the claim or provide any missing documentation. If a provider cannot correct the claim, they are asked to repay the difference between what Medicare paid them and what it should have paid. Unfortunately, the Medicare billing error rate has remained above the 10% legal limit for the past four years. In FY2015 alone, Medicare lost more than $40 billion to improper payments."

Cirillo encourages providers to consider the bigger implications billing has, not only on accurate claims submissions, but also on the health of the staff and residents.

"I think it is incumbent on organizations to connect frontline staff and backroom operations to the big picture," he says. "The billing experience has an impact on the resident and caregiver experience and can result in stress, which in turn impacts health. When you get this wrong, it increases healthcare costs. Administration needs to connect the dots on how [communication among departments and staff education] impacts the experience, quality, safety, even marketing [of a facility]."

Best practices to prevent Medicare fraud and improper payments include:

- Be proactive. Accurate documentation starts with frontline staff. Administrators should be checking in with these individuals on a routine basis to ensure they have the tools and time to effectively document their specific interventions, unique skills, and expertise. Likely the cost of providing these tools (i.e., investing in faster internet, replacing an old desktop computer, ensuring adequate clinical support) will be much less than having to pay Medicare back for a false claim.
- Make sure the care plan outlines realistic goals and the resident's condition has been documented and considered from time of admission. Oftentimes auditors refer to the care plan to determine the resident's condition before therapy. If underlying comorbidities were present that put limitations on the resident, claims for an aggressive therapy treatment plan, such as ultra-high therapy, runs the risk of catching surveyors' attention.
- Ensure staff have the proper and up-to-date licenses and certifications necessary to provide skilled services being billed. The use of an electronic tool, such as a spreadsheet, can be used to confirm staff compliance.
- Be mindful of your subcontracted rehabilitation services. Their financial situation is not on the same chopping block as yours, putting your and their concerns in two different ballparks.
- Cirillo emphasizes the importance of vetting your suppliers and care partners. "One of the roles I en-

visioned when I helped start the patient experience movement was that of Chief Experience Officer. This person is vital in assuring that care partners are a culture fit with the organization. So choosing care partners for culture—not cost—will actually save you money in the long-term."

- You are billing for services daily—support and guidance should be available daily too. Supervisors and managers should be available on a routine basis to answer documentation questions, and staff training and education should be a priority. Posting best practices for documenting skilled services is a simple and yet significant approach to ensuring accurate claims.
- Use tools such as data.medicare.gov to compare your facility's numbers against other facilities' reports in

Fraud and Abuse Resources

Resource	Website
HHS	www.hhs.gov
CMS	www.cms.gov
HEAT Task Force	www.stopmedicarefraud.gov/aboutfraud/heattaskforce
OIG-Fraud	https://oig.hhs.gov/fraud
CMS Fraud and Abuse Products	www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf
CMS Fraud Prevention Toolkit	www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
Frequently Asked Questions: Medicare Fraud and Abuse	https://questions.cms.gov/faq.php?id=5005&rtopic=1887
"How CMS Is Fighting Fraud: Major Program Integrity Initiatives"	www.medscape.org/viewarticle/764791 *Note: To access this program, you need to create a free account.*
Medicaid Program Integrity Education	www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/edmic-landing.html
Medicaid Program Integrity: Safeguarding Your Medical Identity Products	www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf
"Medicare Learning Network® Electronic Mailing Lists: Keeping Health Care Professionals Informed" fact sheet	www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243324.html
MLN Guided Pathways: Provider Specific Medicare Resources	www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_booklet.pdf
MLN Provider Compliance	www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Advisory Opinions	https://oig.hhs.gov/compliance/advisory-opinions
OIG Compliance 101	https://oig.hhs.gov/compliance/101
OIG Email Updates	https://oig.hhs.gov/contact-us

Source: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf

What is the difference between Medicare fraud and abuse?

Medicare fraud typically includes any of the following:

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain Medicare payments
- Knowingly soliciting, receiving, offering, and/or paying for services to induce or reward referrals for items or services reimbursed by Medicare
- Making prohibited referrals for certain designated health services

Anyone can commit healthcare fraud. Fraud schemes range from solo ventures to broad-based operations by an institution or group. Even organized crime has infiltrated the Medicare Program and masqueraded as Medicare providers and suppliers.

Examples of Medicare fraud include:

- Billing Medicare for appointments the patient failed to keep
- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
- Paying for referrals of federal healthcare program beneficiaries

Providers and healthcare organizations involved in healthcare fraud or audit obstruction risk exclusion from participating in all federal health care programs and risk losing their professional licenses.

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice not consistent with providing patients with services that are medically necessary, meet professionally recognized standards, and are priced fairly.

Examples of Medicare abuse include:

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes
- Medicare abuse can also expose providers to criminal and civil liability.

It's important for providers to understand the differences between Medicare fraud and abuse. For example, according to the 2015 CERT Report, the denial rate for SNFs increased from 6.9% in 2014 to 11% in 2015 due to missing or incomplete certification/recertification statements from physicians/NPPs. A Medicare Learning Network call revealed that a major source of improper payments stems from a SNF's failure to obtain the required documentation by physicians (or nonphysician providers) upon admission to certify that each resident in a SNF is, in fact, in need of skilled nursing services. Filing a claim for skilled nursing services without the appropriate certification statement, or one that is incomplete, would qualify as abuse (whether intentional or unintentional) and lead to claims denials and provider noncompliance.

your region. If your ultra-high therapy claims are much higher than neighboring facilities, for example, you should revisit those claims and ensure you have the documentation to prove their accuracy.

Why education is important

The claims submission process is complex, mandated by many policies and procedures outlined by CMS. When compliance with these policies and procedures is not met, providers risk (whether intentionally or with gross negligence) False Claims Act violations and potential criminal or civil proceedings.

"Medicare billing rules can be confusing, so it's more important than ever that providers take active steps to ensure that their claims are billed accurately," says Walter.

Claims are heavily dependent on documentation. Therefore, it is essential, and a common mistake made by facilities when it doesn't happen, that all staff, including the clinical team, receive training in your facility's billing and coverage policies.

Training your entire staff will ensure that services are documented appropriately across the board (i.e., the necessary service items are addressed in the clinical record) and increases, exponentially, the likelihood that your claims will be accurate and deemed appropriate by auditors.

"I am noticing more people being trained in coding. It seems to be a blossoming career choice and is a direct reflection of the need to stay on top of billing requirements and proper coding. I think it is wise that organizations invest in this area," says Cirillo.

When all staff is aware of what is covered by Medicare, it also allows the billing team to be more confident when submitting claims and ensures the documentation supports the need for service, preventing improper payments and a costly potential settlement when Medicare reclaims its funds.

"CMS has also begun to take steps to penalize institutional providers who are found to make higher levels of Medicare billing errors," says Walter. "A new risk-based Additional Document Request (ADR) Limit has been published by CMS that will increase an institutional provider's ADR limit if they are found to have an increased claim denial rate. Therefore, providers with consistently low claim denial rates will enjoy less auditing of their claim submissions and providers with higher claim denial rates will have more of their claims audited—so CMS has initiated a built-in incentive for providers to bill accurately."

Several risk areas designated by the OIG contain documentation vulnerabilities facilities should be aware of and have policies in place to address them, including:

- Resident case-mix reporting
- Therapy services
- Restorative and personal care services
- Federal anti-kickback statute

Walter shares her predictions for the future of Medicare: "Given the new Administration's clear support of Medicare integrity efforts, we suspect that in addition to the continued review of post-payment Medicare claims, Recovery Auditors will also be permitted to review Medicare claims before they are paid—which would prevent Medicare from hemorrhaging tens of billions of taxpayer dollars annually, reduce provider-perceived audit burden, and ultimately extend the life of this vital healthcare program for future beneficiaries."

Where should Medicare providers report fraud and abuse?

OIG Hotline: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

Online: https://forms.oig.hhs.gov/hotlineoperations/index.aspx

Mail: U.S. Department of Health & Human Services
Office of Inspector General
Attn: OIG Hotline Operations
P.O. Box 23489 Washington, DC 20026

OR

Your local MAC

Contractors Who Support Efforts to Prevent, Detect, and Investigate Fraud and Abuse

Contractor	Role
Comprehensive Error Rate Testing (CERT) Contractors	Help calculate the Medicare Fee-For-Service (FFS) improper payment rate by reviewing claims to determine if they were paid properly
Medicare Administration Contractors (MACs)	Process claims and enroll providers and suppliers
Medicare Drug Integrity Contractors (MEDICs)	Monitor fraud, waste, and abuse in the Medicare Parts C and D Programs
Recovery Audit Program Recovery Auditors	Reduce improper payments by detecting and collecting overpayments and identifying underpayments
Zone Program Integrity Contractors (ZPICs) Formerly called Program Safeguard Contractors (PSCs)	Investigate potential fraud, waste, and abuse for Medicare Parts A and B; Durable Medical Equipment Prosthetics, Orthotics, and Supplies; and Home Health and Hospice
Unified Program Integrity Contractor (UPIC)	Will operate under restructured/consolidated Medicare and Medicaid Program Integrity audit and investigation work (not yet implemented)

Source: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf